State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

*Description provided on attachment.

State/Territory: CALIFORNIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s):

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: / / No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

c. Prosthetic devices.

/X/ Provided: /__/ No limitations /X/ With limitations*

d. Eyeglasses.

/X/ Provided: /__/ No limitations /X/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/__/ Provided: /__/ No limitations /__/ With limitations*

b. Screening services.

/__/ Provided: /__/ No limitations /__/ With limitations*

c. Preventive services.

/__/ Provided: /__/ No limitations /__/ With limitations*

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physicians as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B):

/X/ Provided /__/ No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

b. Skilled nursing facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Intermediate care facility services.

|XXX| Provided: |___| No limitations |XXX| With limitations*

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

|XXX| Provided: |___| No limitations |XXX| With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

|XXX| Provided: |___| No limitations |XXX| With limitations*

16. Including psychiatric facility services for individuals under 22 years of age.

|XXX| Provided: |___| No limitations |XXX| With limitations*

17. Nurse-midwife services.

|XXX| Provided: |___| No limitations |XXX| With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

|XXX| Provided: |___| No limitations |XXX| With limitations*

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
TO THE MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related activities

a. Case management services as defined in, and to the group specified in, Supplemental 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1f to ATTACHMENT 3.1-A for County-Funded Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided __X__ With limitations* _____Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__X__ Provided __X__ With limitations* _____Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Provided: + _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Provided: + _____ Additional coverage ++ _____Not provided.

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided: _____ No limitation _____ With limitations*
_____ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Services of Christian Science nurses.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Care and services provided in Christian Science sanitoria.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (S):

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services
X Provided: ___ No Limitations X With Limitations*
___ Not Provided

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal Care Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

PJD

X Provided: X State Approved (Not Physician) Service Plan Allowed
_ Services Outside the Home Also Allowed
X Limitations Described on Attachment
PJD
_ Not Provided:

* Decription provided on attachment.

STAT PLAN CHART

Limitations on Att, 3,1

3.1-B

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1	Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental diseases are covered only for persons under 21 years of age or for persons 65 years of age and over. Services in an institution for tuberculosis for persons under 65 are not covered. Services in the psychiatric unit or TB unit of a general hospital are covered for all age groups.	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindicated Emergency admissions require a physician's, dentist's, or podiatrist's statement supporting the admission. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization by the Medi-Cal Consultant. Mental health services are identified in the Short-Doyle/Medi-Cal (SD/MC) agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA # 88-17

Eff 7-1-88

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